

Letting Go of Restrictive Notions of Manhood: Male Sexuality, Disability and Chronic Illness¹

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In this article I share my personal story and professional perspectives on the impact of disability on male sexuality. Because disability is experienced in the context of gender, I have integrated literature on concepts of male socialization and learning about sex. I explore how acquiring a disability may affect sexuality and create treatment concerns. Finally, I make treatment suggestions for working with men with disability or chronic illness.

KEY WORDS: male sexuality; disability; chronic illness.

PERSONAL PERSPECTIVES

I was baptized into disability on July 27, 1982. I was a lifeguard at the time approaching the end of my shift. In the moments before I broke my neck, I was heading out to fix some buoys. I had sun-bleached hair, a golden tan, and a lean, muscular body. I was 20 years old and at my prime. Everything was perfect except for the ileostomy bag I hid under my shorts.

I had to wear the bag because I had a large section of my intestines removed earlier in 1982. I had been diagnosed with Crohn's disease at age 12 when it was apparent I was not growing at nearly the same rate as other pubescent boys. I was hospitalized once at age 17 and by, age 20 the disease was no longer manageable with diet and drug therapy. I left school in the middle of the spring semester of my junior year for an emergency hemicolectomy. Before being discharged, I had a bout with peritonitis that resulted in a second surgery and the temporary ileostomy.

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It was three months after this surgery when I headed out to fix the buoys. I ran into the lake with a wrench in my left hand. As I dove over the line that separated the depths, I placed my right hand over my bag to prevent it from coming off. The combination of diving over the line and grabbing my bag resulted in angling too deep. My left arm alone was not enough to protect my head from planting firmly in the bottom of the lake. I heard a noise from within my head, it sounded like air rushing quickly out of a tire. I floated to the surface of the water and then struggled unsuccessfully to lift my head up to take a breath. A fellow lifeguard came to my rescue. He asked if I was ok. I said no. I knew I was in trouble. It was at that point my life as a person with a disability began.

Growing up with a chronic illness such as Crohn's disease, I had already developed what I thought were exceptional coping skills. I dealt with managing pain, cramps, diarrhea, special diets, side effects of medications, name-calling by peers, and despair about my body image. I also had to cope with the emotional stress and discomfort of having my private parts exposed in teaching hospitals, the embarrassment of unwelcomed erections during medical procedures, the mortification of waking up from surgery to discover a tube in my penis, and the invasion of being cathed after the tube was removed. I was just learning to deal with wearing an ileostomy bag and the significant scarring on my abdomen.

I guess it is my love for life and fighting spirit that helped me cope overall. But what helped me deal with the ostomy bag was the relief from the pain, cramping, and diarrhea it provided. The absence of pain was pleasure. Feeling good again motivated me to get back into life. Pleasure helped me to compensate for the blow to my body image and ask for my summer job back as a lifeguard. I had just started working and dating again when I broke my neck and became disabled.

As a young man with a C6-7 spinal cord injury (SCI), I would have to deal with much more. I had to face changes in sexual function and response, career options, independence, relating to others, and how others related to me. I would have to deal with bowel routines, wearing an external dwelling catheter and a leg bag, and depending on a wheelchair to get around. I would have to deal with a quad belly, atrophied muscles, paralysis, and spasticity. And, I would have to deal with how all this affected my *sexuality*.

I was deeply concerned about my sexual capabilities from the moment the breathing apparatus was removed and I was able to speak again. My first sexual question was whether I could still have children. I was single at the time and had hardly thought about marriage, let alone having children. I didn't understand the complexity of that question at the time, nor did my physician. The doctor told me my chances of having children were less than 5%. That was it.

There was no acknowledgment of my sexual concerns from the doctor, no follow up questions, no discussion about other changes in sexual response I

might experience, no referral to someone who might help me with my other sexual questions and concerns, and no offer of hope for a sexual future. In retrospect, this is not surprising based on the general level of ignorance about sexuality and disability and the limited amount of sexuality education doctors receive in their formal education and training.

My mother seemed to be the only one at the time who recognized my continuing need for love and affection. She added the statements, "I need a hug" and "I need a kiss" to the list of basic needs on my communication board. These two statements gave me a vehicle for sexual overtures even before I could speak.

My recovery and rehabilitation were riddled with sexual experiences and exploration of my sexuality. The sexual experiences started with the reflex erection I became aware of when I first awoke in intensive care, which nobody talked about, and the limited, pessimistic response from my doctor to my question regarding children. I also experienced reflex erections during bed baths, dressing, positioning, and cathing. Nobody talked about erections then either, except for the one nurse who said "your flag pole is up." With the limited information available to me and the many questions and concerns I had regarding my sexuality and my manhood, I had to work out these issues on my own.

As soon as I was transferred out of intensive care into a room where I had some privacy, I began to explore my sexual potential. My penis seemed to be constantly hard, even though I wasn't aroused. In a halo, with minimal arm and no hand function, still with an indwelling catheter, I attempted to masturbate. I wanted to know whether I could still ejaculate and whether sexual pleasure was still possible. Having no success with masturbation, I attempted to convince my private duty nurse to help me out. We were about the same age and got along very well. She seemed sympathetic and potentially willing to give me a hand, but ultimately she was too nervous about her professional boundaries to help. This was just the beginning of my research on sexuality and disability and the long road to sexual adjustment following my injury.

It has been fourteen years since I was baptized in Lake Mohegan in Fairfield, Connecticut and I have recently celebrated my tenth wedding anniversary. Cheryl and I are expecting our first child, and I've moved from a career in finance to a calling in sexuality education and research focusing on disability and chronic illness. My life since sustaining a SCI has been a slow and steady process of change and growth. It took a while for me to reflect on what had value for me. It also took time to fully accept my disabilities and to come out to others as a person with a disability. I first connected with others who had SCI and eventually connected with others who had different disabilities. I am eternally grateful to my disabled peers who served as role models, mentors, and guides.

Along the way I did a lot of experimentation, at times hurting others' feelings and getting my own feelings hurt, too. I sought out every opportunity to express my sexuality and have it affirmed. I was a consummate flirt, always

testing my abilities. I dated a nurse who cared for me in the ICU and then my primary care rehabilitation nurse while I was still in the hospital. I also went out with my hospital roommate's sister, and even my ex-girlfriend. With each date I would experiment sexually as much as the particular relationship would allow. However, none of these relationships involved coitus so I sought out the services of a prostitute in Atlantic City and a friend's ex-girlfriend at a party.

My male energy drove me to deal with my disability. Competitive swimming, diving, and especially the discipline and focus I learned in karate prepared me well for the rehabilitation process. I was stoic, strong, independent, hard working. I forged ahead, always looking to protect the ones I loved from my misfortunes.

But at the same time, masculinity had its detrimental affects. I pushed away my girlfriend whom I started seeing after my ileostomy and was still dating at the time I broke my neck. I also pushed away my mother, or at least rebelled strongly against her when she tried to take care of me. I reacted most strongly when she was trying to feed me.

As I regained more functional ability, I fought my mother's suggestions to finish school nearby so I could live at home with her. After finishing my outpatient rehabilitation, I returned to Bryant College in Rhode Island where I had been enrolled as an undergraduate finance major before leaving school for surgery. The college assigned a suite mate who was on work study to help me with my personal care. My roommate and closest friends had already graduated and I didn't feel much like making a whole new set of friends. I was primarily focused on finishing my degree as quickly as possible but I was still interested in finding a girlfriend.

In the first year following my injury, I took solace in knowing that I could still please a woman. I was not too concerned about my own sexual pleasure or what else I needed from a relationship. Just being able to win over a woman and have sex was a boost to my self and sexual-esteem. Once that was established, I began looking for a more "serious" relationship. Finding that relationship as a quad, outside the comfortable walls of the rehabilitation hospital and outside the comfortable relationships of ex-girlfriends and strangers who pursued me, was a more risky and painful experience.

I had no problem making female friends. In fact, in college my roommates were jealous of the amount of female attention I attracted and said it was only because of my chair. What they didn't understand is that these women were looking for male friendship that was free of sexual pressure. The women assumed I was *safe*. I was not perceived as a potential sexual partner, but the perennial friend. It seemed impossible to make the transition from friend to sexual partner in relationships in which I had established an intimate connection. I even brought this up as a primary concern with my physiatrist. His meager consolation was that some people are lucky to find love only once in their lives.

I felt like I was never going to connect sexually with someone on the level

that I was interested in again, until I met Cheryl more than 12 years ago (Tepper, M. & Tepper, C., 1996). We met in a computer class at Bryant College and it turned out that we lived diagonally across the hall from each other. My father-in-law always asks us who made the first move. I think she did; she thinks I did. The truth is that there was a real mutual attraction.

I knew Cheryl was right for me because I felt totally accepted when I was with her; I did not feel my disability was an issue at all. I had made myself a promise even before I broke my neck that I would marry the first person I dated for six months. I was so overwhelmed with this requited love that by five months I proposed. I was afraid if I lost Cheryl I might never find a love like her's again. We were married 18 months later.

There were concerns from both families because of my disability and our differences in religion. My mother expressed concern about the religion of our children. This prompted me to reveal to her the doubts of my being able to father children. I also told my mother about my discussions with Cheryl about adopting a child if it turned out that I could not impregnate her. Both my mother and Cheryl's parents were concerned for Cheryl and the burden I would be on her over the long run. Fortunately, neither Cheryl nor I saw me as a burden.

We've had a wonderful marriage. We have adopted a lifestyle that is less traditional than other heterosexual marriages and it works well for us. I do the dishes, the laundry, and the bathrooms while my wife is the primary bread winner working as a senior systems analyst. I enjoy decorating, shopping, and picking out clothes. Cheryl puts up the shelves, fixes the dryer when it breaks, washes the car, paints and wallpapers. The formula that works for our relationship is based on equality, respect, mutual acceptance, trust in each other, realistic expectations, open and honest communication, and flexibility in roles. Although none of these qualities is unique to a relationship in which one or both partners have a chronic illness or disability, we believe they are critical for long-term success and happiness.

I was not born into disability secure in my manhood or comfortable breaking out of stereotypical male roles. What it meant to be a *real* man was deeply ingrained in me by the time I was 20. Fortunately, after many years of work, I am relatively free of socially imposed concepts of male sexuality and masculinity. Even at this juncture in my life, however, I sometimes wrestle with internalized notions of male roles as I prepare to stay home with our baby when my wife goes back to work.

What I have learned since formally studying human sexuality is that male sexuality goes way beyond the apparent issues of erectile function, who should do the dishes, and who should make more money. There are lasting and lingering effects of the indirect education and training to be a man in the United States. Although each man's experience may be different, we still live in a society that is androcentric, gender polarized, and works to socially construct

our gender (Bem, 1993).³ How we are socialized into gender will affect our reactions to events that threaten our identity and will also affect how we deal with changes in our ability to perform our expected gender roles.

MALE SOCIALIZATION AND MASCULINITY

The social construction of masculinity begins as soon as we are born and continues for the rest of our life (Bem, 1993; Money & Tucker, 1975; Zilbergeld, 1992). Money and Tucker (1975, p. 86) assert we learn gender identities and expected gender roles much the same way we attained speech. We are born hard-wired for speech, but not programmed. Programming for speech occurs as we are exposed to the language spoken to us by our parents and those around us in our society. From the moment the doctor pronounces "it's a boy" males begin to establish a sense of gender-identity. By the time we can speak, we can already identify our gender (Thompson, 1975). As we learn the language of our society, we also learn what the expected gender-roles are for us. According to Bem (1993), "male-female difference is superimposed on so many aspects of the social world that a cultural connection is thereby forged between sex and virtually every other aspect of human experience, including modes of dress and social roles and even ways of expressing emotion and experiencing sexual desire" (p. 2).

According to Zilbergeld (1992), by the age of six or seven most of the important lessons in male socialization have been learned. One of these messages is "don't be like a girl" (p. 23). Zilbergeld explains, "Since females of all ages are the softer ones—the people who express feelings, who cry, who are

³The concepts of androcentrism, gender polarization, and the construction of gender identity are advanced by Sandra Bem in her work *The Lenses of Gender* (Bem, 1993). Androcentrism refers to male-centeredness—a definition of males and male experience as a neutral standard or norm, and females and female experience as a sex-specific deviation from that norm (p. 2). Gender polarization refers to the perceived difference between women and men that are used as an organizing principle for the social life of the culture. According to Bem, gender polarization operates by defining mutually exclusive scripts for being male and female and by defining any person or behavior that deviates from these scripts as problematic (Bem, 1993); androcentrism and gender polarization work to limit options and hence human potential. "The gender-polarizing concepts of a real man and a real woman give both men and women the feeling that their maleness or femaleness is something they must continually construct and reconstruct, rather than something they can simply take for granted. In the context of an androcentric culture it is the males in particular who are made to feel the most insecure about the adequacy of their gender. Androcentrism exacerbates the male's insecurity about his status as a real man in at least two different ways. It so thoroughly devalues whatever thoughts, feelings, and behaviors that are culturally defined as feminine that the gender boundary has a more negative cultural meaning for men than it has for women—which means, in turn, that male gender-boundary-crossers are much more culturally stigmatized than female gender-boundary-crossers. At the same time, androcentrism provides such an unreachable definition of what a real man is supposed to be that only a few men can ever begin to meet it" (Bem, 1993, p. 150).

people oriented—not being like them is an effective way to suppress the softer side of males” (p. 23). Negative reinforcers such as name-calling—“sissy” “girl” or “fagot”—keep boys from straying too far from what is expected. They also send the message that to be masculine, you must be heterosexual (Herek, 1986).

Homophobic name-calling is used to keep boys in line (Linn, Stein & Young, 1992). Name-calling creates or reinforces hostility toward the gay and lesbian population and it forces all children to follow strict sex-role behaviors to avoid ridicule (Gordon, 1983). Homophobia, in this sense a fear of being perceived as gay, is said to be perhaps the greatest pressure boys face while growing up (Friedman, 1989) and is considered the ultimate weapon in reinforcing rigid sex-role conformity (“Homophobia and Education,” 1983). According to Friedman (1989), homophobia sparks male hatred of women and fear of closeness to other people. Rigid sex role stereotypes prevent heterosexual males from establishing meaningful and intimate relationships with other men and women and set up male-female relationships based on male superiority that preclude the possibility of true intimacy (Neisen, 1990).

Boys also learn the primary thing in life is performing (Farrell, 1986; Zilbergeld, 1992), or “getting the job done” (Bem, 1974, p. 156). In general, masculinity and masculine traits seem to reflect a competency cluster (Broverman, Broverman, Clarkson, Rosenkrantz & Vogel, 1970). The end result of male socialization is a set of defaults that are programmed by society, culture, media, family, and religion. The typical male attributes are supposed to be: strength and self-reliance, success, no sissy stuff or don’t be like women, sexual interest and prowess, active, independent, tough, aggressive, dominant, stoic, and never cries (Bem, 1974; Broverman et al., 1970; Herek, 1986; Zilbergeld, 1992). These defaults define a fanciful standard of masculinity. Males who internalize these standards are prone to experience anxiety that they will fail to measure up to their role. According to Herek, “The source of this anxiety is fear of losing one’s sense of self, or identity, as a heterosexual man (which is equivalent to a male’s identity as a person)” (p. 567). The socialization of males provides very little that is of value in the formation and maintenance of intimate relationships. Male socialization also carries over into what boys learn about sex.

WHAT BOYS LEARN ABOUT SEX AND MANHOOD

What boys learn about sex and manhood becomes a critical treatment concern when they reach adulthood and are faced with sexual dysfunction resulting from a disability or illness. According to Zilbergeld (1992), boys learn that their

manhood is tied to their penis, and having and using erections has something to do with masculinity: "before having sex with partners or even themselves, boys know that sexual interest and prowess are crucial to being a man . . . Since sexuality is such a crucial component of masculinity, males feel pressured to act interested in sex whether or not they really are. . . . This is a great setup for faking, lying, and feeling inadequate" (p. 32).

Zilbergeld asserts that what adolescent boys learn about penis centered sexuality creates an incredible confusion between personhood or identity and one's sexual organ. When their penis doesn't operate according to spec men equate this with loss of manhood. This is no different for a man who acquires a disability.

According to Zilbergeld (1992), boys learn a fantasy model of sex: "It's two feet long, hard as steel, always ready, and will knock your socks off" (p. 37). Zilbergeld explains further: "Sexual education goes on all the time . . . [via sexual jokes, sexually implicit or explicit movies, novels or television that involves sex or adult relationships] . . . Because all the media portray essentially the same sexual message, it's virtually assured that all men and women will learn the same model of sex . . . The sexual messages conveyed in our culture are the stuff of fantasy . . . Because we don't have any realistic models or standards in sex, we tend to measure ourselves against these fantasies . . . We usually aren't even aware that we're comparing ourselves to anything. We just know that we feel bad because our equipment and performances aren't what we wish they were . . . end up feeling inadequate about our bodies and our partners' . . . We compare ourselves to what we have learned, and almost everyone feels that they've come out on the short end" (37-42).

ADD AN ACQUIRED DISABILITY

What happens if we lose our ability to attain or maintain an erection, or to ejaculate as a result of an acquired disability? What happens if we lose sensation in our genitals, if we use a catheter, or if we have physical limitations? Whether resulting from Crohn's disease, SCI, or any other acquired disability or chronic illness, a medical impairment inevitably impacts male sexuality. Issues such as dependency, diminished body image, impaired sexual function, and loss of earning potential may threaten a man's gender identity or core sense of himself as a man and his ability to carry out established gender roles.

Men arrive at rehabilitation with all the baggage society, culture, the media, parents, friends, and religion packed for us. We were socialized to be strong and self-reliant, successful, manly, and sexual performers. We learned the same myths and fantasy model of sex as our peers. What happens when we are faced with the loss of strength and self-reliance, loss of sexual prowess, and

loss of success? What happens when we do not have our penis to fall back on or to stand up and let us be counted as a man?

For some men with an acquired disability loss of strength and self-reliance, loss of sexual prowess, and loss of success can equate to loss of manhood. To men who are faced with sexual problems and physical impairments, the perceived loss of their manhood or sexuality could be devastating. Zilbergeld (1992, p. 20) discusses this link between gender roles and gender identity as follows:

Because we learn from an early age that manhood is conditional rather than absolute, males are in constant danger of losing their manhood and their identities. Not making the team, not being willing to fight, not performing in bed, losing a job—that's all it takes and our man no longer believes that he's a man . . . [furthermore] their behavior must conform to what is considered manly. Any slight deviation, small sign of weakness, and they might lose their place among other men and be labeled "lady," "woman," or "pussy"—all signifying a non-man or less than a man. But if a man isn't a man, what then is he? The answer most seem to believe is: Nothing at all. For their identities are inextricably linked to their gender-roles. If the results of changing one's behavior can be so dire as a loss of identity, one doesn't take change lightly . . . (p. 20).

If it is impossible for an able-bodied man to meet the fantasy model of sex, a man with a disability faces an even more devastating task to live up to the ideal male model. As long as a non-disabled man continues to function and perform sexually, as long as he still attains an erection and ejaculates, he can continue to strive for the fantasy and operate under the myths described earlier. The able-bodied, sexually functioning man may never have reason to question the quality of his sexual encounters. For the man with a disability with impaired sexual function, the realization that he doesn't match up may be painfully clear.

If these fantasies and myths are not dispelled in sexual health care, the man with erectile dysfunction, inhibited ejaculation, loss of sensation, or physical limitations might conclude that his sex life is over. Attempts at sex may lead to frustration or anger and to relationship conflict. Even if a man is able to attain an erection and ejaculate he may be disappointed if his erection isn't as firm or if his ejaculate doesn't shoot as far as compared to his pre-disability performance. The recall of pre-disability performance is highly subjective and still clouded by the fantasy model. When sexual functioning is lost or impaired, men will need help in redefining their concept of good sex and of manhood to be capable of finding enjoyment in their sexuality.

But society teaches men many destructive myths about sexuality that must be surmounted first. Some of these myths are described by Zilbergeld (1992) as follows:

- "We're liberated folks who are all comfortable with sex" (p. 42). This myth is inconsistent with messages we receive growing up that sexual pleasure is bad and that sex is private. It also leads to arrogance and

narrow mindedness about sex, thus making communication and learning more difficult.

- “A real man isn’t into sissy stuff like feelings and communicating” (p. 44). Sex is used for expression of emotions instead of verbal communication. Therefore, men never have the opportunity to develop comfort or skill in talking about sex. However communication around sexual issues is crucial to adapting to sexual changes and maintaining intimacy with a partner after acquiring a disability.
- “All touching is sexual or should lead to sex” (p. 45). Resultingly, most men are closed to touch as an option for getting needs for signs of love and support met and for bonding. This may also lead to men distancing physically in the presence of a disability that impairs sexual functioning.
- “A man is always interested in and always ready for sex” (p. 47). This belief leads to pressure to be sexual before we are ready. There is pressure to become sexually active to prove to ourselves and others that we are still normal (Blumenfeld, 1994).
- “A real man performs in sex” (p. 48). Therefore performance proves you are a man. Conversely, if we can’t perform, we are not real men anymore.
- “Sex is centered on a hard penis and what’s done with it” (p. 49). This creates pressure to have and to keep an erection since “the desired penis functions automatically and predictably, just like a well-oiled machine . . . [and] means that the penis should function regardless of any other considerations” (p. 51).
- “Sex equals intercourse” (p. 51). The absolute need to have intercourse as a necessary part of sex can create a number of problems. “When the penis doesn’t operate as we want it to, many of us get upset and refuse to have sex at all. If we can’t do it the right way, ‘why do it at all’” (p. 52)? This thinking leaves men to deprive themselves of pleasure because they can’t perform sexually like they did before disability or illness.
- “A man should be able to make the earth move for his partner, or at the very least knock her socks off” (p. 53). This keeps the performance pressure on and the focus more on the pleasure of the partner. “It can [also] make it difficult for a man to feel good about a sexual encounter that consists primarily of being pleased by his partner” (p. 54).
- “Good sex requires orgasm” (p. 55). Orgasm and more specifically ejaculation in men is interpreted as a clear sign of enjoyment. Since, according to Zilbergeld, many men don’t get much out of sex besides ejaculatory release, they don’t see the point in sex without it. It is easy for men who have not experienced orgasm or ejaculation after disability or illness to adopt this attitude.

- “Good sex is spontaneous, with no planning and no talking” (p. 59). Men hold on to the idea of fantasy sex “where people instinctively know what the other wants and willingly provide it, where there are no serious problems, where we can have whatever we want and all we want of it” (p. 59). It is more comfortable to hold onto the fantasy because planning requires talking and explicit approval. The perceived loss of spontaneity after disability or illness gives men another reason to believe good sex is no longer possible.
- “Real men don’t have sex problems” (p. 60). Therefore men are not readily willing to admit or acknowledge sexual problems since sexual problems are equated with diminished manhood. The health practitioner will need to take responsibility for gently initiating the discussion of sexual problems.

Zilbergeld (1992) and Farrell (1986) argue that men get a raw deal in their socialization. Reasons supporting the raw deal argument include the facts that men live fewer years than women and that men are more likely to commit suicide, to become dependent on drugs or alcohol, become psychotic, suffer from stress related illnesses like ulcers and heart disease, and be involved in serious accidents. Potential violence is a fact of life for boys from the first day they encounter other boys. It is easy to see how these facts attribute to the over-representation of men in rehabilitation units and hospitals who are left with permanent disabilities.

TREATMENT CONCERNS

As described, the subtle and not-so-subtle messages accumulated over the years can leave men with an acquired disability feeling the loss of manhood. Medical impairment leads to disability and disability, to dependency. Often after a disability, a man moves from a position of independence to a situation where he is forced to depend on his mother or spouse or partner. Dependency makes a man feel childlike, like a non-man. Complicating the matter is that the majority of rehab nurses who the man in the rehab unit or hospital depends on for his basic care are women.

When faced with loss of strength and self-reliance, men are unable to express the fear and despair they are feeling with their new disability since they are trained to mistrust and dislike the more vulnerable and expressive side of themselves (Zilbergeld, 1992). Men’s inability to express fear and despair limits their ability to get comforted, to find release in tears, and may manifest itself in

denial or anger. Denial and anger may, in turn, impede the rehabilitation process.

“Because anger is one of the few feelings men believe they can have, it’s often a mask for other feelings, especially such as feeling hurt or fear, that suggest weakness. It’s much easier for men to deal with anger than these other emotions” (Zilbergeld, 1992, p. 239). Accordingly, men have a tendency to display excessive masculinity when they are afraid and, conversely, to act out of a sense of imperfect masculinity (Pittman, 1991).

Because of emphasis on strength and self-reliance men may deny they need help adjusting (Zilbergeld, 1992). They try to go through the rehabilitation process on their own. They often have trouble admitting they need help and do not want to burden their loved ones with complaints. Therefore, men don’t acknowledge worries or fears to providers or partners. This hinders intimacy with their partners which adds distance in a relationship when closeness is needed.

“Men drown feelings in drugs, alcohol, or sex to satisfy need for body contact/touch and distraction from feelings” (Zilbergeld, 1992, p. 30). Therefore, unexpressed feelings over losses may lead to substance abuse. Rehab providers and loved ones may overlook the substance because they feel that the abuse is justified because of the dreaded physical condition the man is in.

Since “parents stop touching their boys early on . . . men lose sight of their need for touching except as a part of roughhousing or sex” (Zilbergeld, 1992, p. 27). Therefore, many men are closed to touch. If the disability results in diminished or lost ability to sense genital stimulation, men are usually unaware of the sensual potential of other parts of their body. Sexual satisfaction becomes impossible.

Many men still have sports as an outlet. “In sports many of the prohibitions on males are lifted. A man can be as emotional and expressive about his favorite team and players as he wants . . . Playfulness and creativity are allowed . . . There’s even a lot of physical contact . . . one could express anger without much risk . . . Sports is one of the few places where men can safely become boys again . . . [displaying] expressiveness and playfulness” (Zilbergeld, 1992, p. 31). Sports provides men an opportunity to prove themselves and can be a vehicle to help men reestablish their masculine identity.

TREATMENT SUGGESTION FOR SEXUAL HEALTH CARE

Attention to comprehensive sexual health care is desperately needed to help restore a man’s sense of manhood and help him enjoy his sexuality once again considering the possible treatment concerns summarized below:

- childlike feelings of dependency;
- physiological changes in sexual function;
- inability to express fear and despair;
- denial, repression, anger, and misinformation around sexual issues;
- the wish not to burden loved ones, and;
- the potential for substance abuse to soften the sexual trauma.

I believe restoring a sense of manhood and enjoyment of sexuality is possible based on my personal experience and my theoretical understanding of the social construction of gender and of sexuality. The theory operates under the assumption that what is socially constructed can be deconstructed and reconstructed (Herek, 1986).

Health practitioners can help the process of deconstruction and reconstruction by:

- helping men unlearn sexual myths through facilitating the critical examination of what men learn about sex and manhood;
- helping men learn or relearn facts about human sexuality to help compensate for the general lack of accurate sexual information people have before their disability or illness;
- helping men to understand the physiological effects of disability on their sexual functioning;
- providing information on solutions to impaired sexual function and options for sexual expression;
- helping men to improve their communication skills around sexual issues.
- reacting constructively to anger by deflecting the words or behavior whenever possible and guiding men to explore the underlying causes of their emotions;
- anticipating sexual questions and concerns and looking for teachable moments during times of intimate care to broach the subject;
- encouraging men to take control and direct their own rehabilitation process as much as possible;
- providing competitive recreational activities;
- spelling out the benefits of adapting a more flexible gender role;
- teaching men to focus on pleasure and intimacy instead of performance and orgasm;
- not ignoring substance abuse.

In theory, if men were taught as children that being a man is not conditional and that manhood cannot be lost through loss of genital function or the inability to perform other traditionally male-coded sex roles (Bem, 1993; Money & Tucker, 1975), then men would not suffer the same major blow to

their masculine identities when confronted with the changes associated with disabilities. But reconstructing concepts of gender identity as men age, like learning a new language, is not easy. Learning the basics of a language in the classroom is only a start, as is the limited amount of sexuality education we are able to provide considering shorter lengths of stay in rehabilitation hospitals today. To really learn a language, it is helpful to be submersed in the culture where the language is spoken. Likewise, to really accept a new image of male sexuality, men must have an opportunity to learn from others with SCI who have maintained a positive sense of their sexuality with disability (Tepper, 1992). The re-education process will entail assessing the man's sexual knowledge, attitudes, and behaviors acquired before and after his disability. The sexual assessment should be followed by the provision of appropriate information, suggestions, and referrals if necessary. Ideally there should be health practitioners on the staff who have received specialized training in providing comprehensive sexual health care. Like comprehensive rehabilitation, comprehensive sexual health care addresses sexuality from a biopsychosocial perspective using an interdisciplinary team approach (Tepper, 1997). Hospitals, professional organizations, and universities that wish to provide continuing education and training in comprehensive sexual health care to health practitioners can now obtain an extensive curriculum that was developed with the support of a grant from the Paralyzed Veterans of America, Spinal Cord Injury Education and Training Foundation (Tepper, 1997).

SEXUAL HEALING

Sexual health care must deal directly with issues of sexual pleasure if there is going to be total sexual healing. Men need new messages to replace the old ones learned over a lifetime. Suggested messages include the following:

- ejaculation and orgasm are not the same thing;
- it is not necessary to ejaculate every time you have sex;
- orgasm is possible without ejaculation;
- sexual activity without orgasm or ejaculation is still sex and is a viable alternative to having no sexual contact at all;
- there are many ways to receive and to give sexual satisfaction without penile-vaginal intercourse;
- sexual pleasure and even orgasm is possible through touching, kissing, hugging, masturbation, oral, and anal sexual activities
- good sex does not have to be spontaneous—talking about sex and planning sex can lead to good sex.

Simply sending messages will not be enough, though. Assuming a man desires to be sexually active again, and assuming excitement problems of attaining and maintaining an erection are organically based and managed with one of the options for erectile dysfunction, or assuming he decides to have sex without an erection, he will need guidance in finding out his optimal conditions for arousal. Common conditions men have reported as necessary to enjoy good sex and that lead to increased arousal include being more open to the experience, more confident, more rested, and more relaxed (Zilbergeld, 1992). Achieving these conditions subsequent to acquiring a disability is not a quick and easy path and will require implementation of the forementioned treatment suggestions.

A man will also need guidance in relearning about his body and what types of stimulation bring him pleasure. There are commonly used techniques to help increase awareness to areas of our body where sensation is still intact and where we may be open to sexual stimulation. Sensate focus exercises described by Masters and Johnson (1970), pleasure mapping described by Stubbs (1988), and charting your personal extragenital matrix described by Whipple and Ogden (1989) are three options for increasing sexual communication and sexual pleasure. Some of these sexual exercises may be performed alone while others will require the help of a partner or sexual surrogate.

It takes many painful steps to recover sexual pleasure after a disability. But it can be done. I've done it.

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